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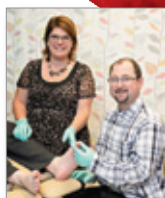
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Message from the President

by Stephen Hartman, D.Ch., B.Sc. Podiatric Medicine, CFPM President

VOLUNTEERS ARE THE REASON FOR THE CFPM'S SUCCESS

As I begin a new term as president of the CFPM I reflect on the past in order to prepare and plan for the future.

I reflect on the early days of the CFFS in 1999 (yes, we use to be called The Canadian Federation of Foot Specialists!). It seems like just yesterday we had our first conference in Waterloo with about twenty delegates and a handful of exhibitors. Since that time we have developed so many programs and offerings that I wouldn't even try to begin to list them all.

So what is it that makes the CFPM so successful? Great conferences? Ongoing government relations? Bridging gaps between insurance companies and practitioners? Member benefits? None of this would happen without the strong contingent of volunteers. It's the volunteers that have built a strong foundation and have grown the CFPM.

For the past 17 years the CFPM has had dozens and dozens of people donate endless hours and expertise. I would like to say "thank you" to those volunteers. We wouldn't be where we are today, without your help.

The CFPM board of directors is a committed group of approximately 8 – 12 individuals who work selflessly to "give back" to their profession. Why are volunteers so important to the CFPM?

Quite frankly, without volunteers, we wouldn't exist. The CFPM has one part-time employee. We are unlike other professional health care associations who may employ many full time staff.

We are a young profession, being approximately 30 years in existence means we have a lot of work to do in catching up to the older, established professions.



We are a small profession with less than 1000 practitioners across the country, which means a larger percentage of members need to help out.

Limited financial resources put a strain on our ability to do things. Volunteers are critical to managing our financial limitations.

Podiatry/chiropractic in Canada is an eclectic group. We are diverse in geography, education, legislation and scope of practice. A diverse board of directors helps us understand our membership's needs and concerns.

The future successes of the CFPM will continue to rely on the commitment of its volunteers. As one world renowned speaker said to me recently, "wow, the CFPM punches above its weight class". This is a testament to our hard working volunteers.

We, more and more, tend to work independently as private practices grow. Professional volunteerism provides private practitioners with a opportunity to connect with others in their profession.

The future successes of the CFPM will continue to rely on the commitment of its volunteers. As one world renowned speaker said to me recently, "wow, the CFPM punches above its weight class". This is a testament to our hard working volunteers.

I want to give a big shout out to all the CFPM volunteers, past, present and future. Thank You!

Ontario Clinic Regulation

In 2015, a group of twelve health regulators in Ontario formed a Working Group and began exploring the idea of regulating health clinics in Ontario to enhance the protection of patients and the public. The Working Group believes there is an opportunity to strengthen accountability and increase transparency in the healthcare system. This goal is in line with the regulators' duty to protect and promote the public interest in Ontario.

This project and consultation is not a government initiative. It is undertaken by a group of health regulators in Ontario.

There is general concern that regulated health professionals working in some settings have no control over important clinical issues, and that individual regulatory colleges have no authority over a business or corporation.

A public consultation process ended Dec. 31, 2015. The group will now digest the information and determine if such regulation is even necessary and how they might initiate clinic regulation.

For more information visit OntarioClinicRegulation.com

CFPM attends Michener Institute's Meet and Greet

On Jan. 21, 2016, the CFPM attended the Chiropody Program's Annual Meet and Greet at the Michener Institute. CFPM Board Members, Stephanie Playford and Trina Scarrow met with the future chiropodists, colleagues and vendors to discuss the CFPM and benefits of membership. Thank you to the chiropody students for the invitation and organizing an outstanding event.



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Many of New Brunswick's top tourist destinations are within an easy commute from the city. The city of Moncton is just a drive away from idyllic beaches and magnificent natural wonders.

Gait Analysis Research Lab

A tour of Gait Analysis Lab at the University of New Brunswick, Fredericton is scheduled for Thurs. June 9, 2016. The Andrew and Marjorie McCain Human Performance Laboratory has a long history of research in clinical motion analysis and has developed one of the most advanced movement analysis laboratories in Canada. UNB houses the world's most advanced 16 megapixel motion capture system to accurately track and record movement. The high resolution of the cameras enables researchers to study the details of locomotion and mobility impairment to a much greater degree. This makes it

possible to develop more meaningful biomechanical models of the human body. For example, allowing researchers to accurately predict the effects of surgical interventions in people with foot disorders.

Additional Topics include:

- Multi-segment foot modeling in biomechanics and clinical application
- Technology and human function
- Laser applications in podiatry
- Podiatry and compounding pharmacy
- Real estate and your practice
- Diabetes in Canada
- Social media
- Collaborations with a certified orthotist
- And more

This seminar will support the New Brunswick Podiatry Association and legislative changes for pharmacology and prescription privileges in that province.



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2016 Summer Getaway Seminar

Speakers

Dr. Ashraf Badawi



Dr. Ashraf Badawi is currently an Associate Professor of Dermatology at the National Institute of Laser Enhanced Sciences, Cairo University, Egypt and a visiting Professor of Dermatology at Szegeed University, Hungary. Dr. Badawi has graduated from the Faculty of Medicine Cairo University, Egypt in 1992. In 1997, he obtained the MSc degree in Dermatology and Venereology followed by a Diploma in the Laser Applications in Biology and Medicine in 1998 from Cairo University too. In 2001, Dr. Badawi obtained a Diploma in General Surgery from the Faculty of Medicine, Cairo University. In 2007, Dr. Badawi received a PhD degree in Laser Applications in Dermatology from the National Institute of Laser Enhanced Sciences, Cairo University, Egypt. In 2011, Dr. Badawi obtained a second PhD in Clinical Medical Sciences from Szegeed University, Hungary.

Dr. Victoria Chester



Dr. Chester is a Professor in the Faculty of Kinesiology and Co-Director of the Andrew and Marjorie McCain Human Performance Laboratory at the University of New Brunswick. Dr. Chester has a BSc. in Human Kinetics from the University of Guelph, a Master's degree from Laurentian University and a Ph.D. in Mechanical Engineering from the University of New Brunswick.

Dr. Gwyneth de Vries



Dr. de Vries received a Bachelor of Science in Biochemistry, and a Masters in Cardiovascular physiology. She studied Medicine and Orthopedic surgery in Calgary, then did Foot and Ankle Fellowship training in Vancouver. She has worked in New Brunswick since 2007 with special interests in the high risk foot and sports injuries of the foot and ankle (particularly runners and dancers).

Brian Cormier



Brian Cormier, President, Bricor Communication Brian Cormier is a writer, editor, communications strategist and newspaper columnist with a career that has spanned more than 25 years. He has worked in a variety of communications-related positions in the both the public and private sectors, including the Office of the Premier of New Brunswick and agencies such as Bristol Group, Shift-Central and Colour.

Dr. Stephen Hull



Dr. Hull is a graduate of Queen's University Belfast and received his postgraduate training in Northern Ireland and New Zealand. He moved to Saint John, NB in 2011 and is currently Head of Division Of Internal Medicine and Chair of Medical Quality Improvement Committee and Co-Chair of 4CN Leadership Group. He is a Member of New Brunswick Dept of Health Diabetes Task Group a member of Saint John Local Area Diabetes Group and a Member of New Brunswick Dept of Health Antibiotic Stewardship Working Group.

Ray Lalonde



Ray is a licensed realtor in the Barrie/Orillia Ontario area for 12 plus years. He has experience in residential and commercial activity and has helped business clients meet their leasing, purchasing and investment needs. He is married to Olga Lalonde and together they have purchased 3 different properties for her clinic.

Allan Moore



Allan Moore is a Certified Orthotist with over 30 years' experience working in the private and public sector designing custom orthotics for diverse patient populations. He has been in private practice for the last 18 years and has been heavily involved with provincial and national initiatives within the fields of Prosthetics & Orthotics throughout this time. He is Past Presidents of both the Ontario Association of Prosthetists and Orthotists and the Canadian Board for the Certification of Prosthetists and Orthotists. In 2014 he received the Fellowship designation, an award presented to those who have made an outstanding contribution in the promotion and education of the profession.

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To Be or Not To Be... a CFPM Member

by Trina Scarrow

I find myself here writing to you all thinking of not only the benefits of CFPM membership, but also of how important it is to be a member of, or involved in our professional associations. Most of us only have so much money to budget for the year and need to make wise decisions. Household budgets, kids, professional and practice budgets all take up a piece of the pie. So why seek membership in our professional associations? For many of us here in the podiatry world, membership is a luxurious option, not mandated as it is in other health professions. So why do we? Why should we?

We all know that membership has its perks. There are many benefits received as being a member of the CFPM. But equally important is the work done by the CFPM and all professional associations. This work not only benefits members, but every member of the profession practicing in this country.

Now, many of you, when considering where to spend your hard earned dollars will ask "What is in it for me?" Let us start with the direct benefits of CFPM membership. CFPM membership is a valuable resource. It provides us with discounts on professional insurance, office management and charting software, websites, online marketing, online learning, access to international resources, educational programs, professional publications, office products, and educational products for patients to name a few. Not only does the CFPM bring all of these resources together, they have been personally vetted and evaluated by a group of knowledgeable colleagues, such that members can be assured of the quality of the resources. All of the tangible benefits alone will more than pay for the cost of CFPM membership when utilized even partially.

Have you considered perhaps the most valuable resource? Professional connectivity? Being a member of the CFPM grants you access to colleagues, their ideas, experience, and established relationships. To have the ability to comfortably reach out and send an email, or ask a question is priceless. So often in this profession, after graduation people go their separate ways. Many will end up

working closely with members of other health professions, but have little day to day interaction with members of the same profession. If you are facing challenges in your practice, you're not likely the first person to have this issue. A little guidance from experienced colleagues can go a long way. The CFPM has a mentorship program for young practitioners, which specifically aims to match new practitioners with experienced practitioners. Mentors are willing to share not only their successes but their failures, such that you can learn and grow from their experiences. Learning does not stop after graduation, it in fact has only just begun to prepare you for what is to come. Successful professionals engage in life-long learning, not only in terms of education, but also in terms of human interaction.

So now I would like to ask you not "What can the CFPM do for me", but "What has the CFPM already done for me?" Whether you are, ever were, or will ever be a CFPM member, the work of the CFPM has touched, enriched and helped to ensure your professional success. Not only do they host first class educational opportunities for all, the CFPM works tirelessly representing our profession. Advocacy work with other health professions, educational institutions, international connections, the government and insurance industry is continually ongoing. Without this representation we would surely fall behind many other professions, all clamoring to get ahead of each other, eager to take a slice of the pie. We would be buried in the dust without a strong voice and representation. This impacts every single member of our profession and our success, not only today but in the decades ahead. Without the advocacy of our associations on our behalf, our credibility would surely erode as others step in line to replace us.

In conclusion, I would like you to envision the future without strong advocates like the CFPM to support and fight for our profession. Perhaps the final question should not be "Can I afford membership in our professional association", but "Can I afford not to be a member, or not to have a professional association to belong to?"

Use of CFPM Logo – Guidelines



CFPM Members are encouraged to use the CFPM logo on their websites, brochures and elsewhere to indicate membership with the Canadian Federation of Podiatric Medicine as long as they comply with usage guidelines and are current CFPM members.

In general, we want the logo to be used as widely as possible to promote the Canadian Federation of Podiatric Medicine. Derivative versions of the CFPM logo are generally prohibited, as they dilute the CFPM's brand identity.

Use of the CFPM logo by a CFPM committee or board member in conjunction with committee or board activities requires prior approval by the CFPM CEO and/or CFPM board of approval.

Use of the CFPM logo, other than to represent membership, requires written consent and approval and must comply with the usage guidelines.

The CFPM logo must be obtained from the CFPM directly, to insure accuracy and appropriate resolution. The CFPM logo is available in several formats.

Logo Colour: The logo may appear in only three color choices – black, white or red. Do not use any other colors in presenting the logo or alter these color selections in any way.

Logo Size: The logo must always be displayed at a size large enough to read the logo type. This will vary based on the resolution of the medium it is being used in – but as a general rule the logo circle should be no smaller than 2.5 cm (1") in height.

Discontinued Use: Use of the CFPM logo is prohibited to indicate membership by non members. If the practitioner is no longer a CFPM member, it is mandatory that the CFPM logo is removed from their website and/or written materials.

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RESEARCH

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Primary care referral to multidisciplinary high risk foot services – too few, too late

D Plusch¹, S Penkala^{1,4*}, HG Dickson^{2,4} and M Malone^{1,3,4}

Abstract

Background: To determine if patients with no contact with a multi-disciplinary team High Risk Foot Service (MDT-HRFS) had an increased rate of hospital admission for diabetes foot infection compared to patients with contact. Secondary aims were to report on clinical outcomes.

Methods: A retrospective study was conducted at a major tertiary referral hospital in metropolitan Sydney over 12 months. An ICD-10 search of the electronic medical record system and paper medical charts identified patients with diabetes mellitus (type 1 or type 2) and a primary admission for diabetes foot infection (DFI). Patients were categorised as having contact or no contact with an MDT-HRFS.

Results: One hundred ninety-six hospital admissions (156 patients) were identified with DFI over a 12-month period. Patients with no contact with a MDT-HRFS represented three quarters of admissions (no contact = 116, 74.7 % vs. contact = 40, 25.6 %, $p = 0.0001$) and presented with more severe infection (no contact = 39 vs. contact = 12). The odds of lower extremity amputation increased five-fold when both no contact and severe infection occurred in combination (no contact with severe infection and amputation = 34, 82.9 % vs. contact with severe infection and amputation = 7, 17.1 %, OR 4.9, 95 % CI 1.1–21.4, $p = 0.037$). Using estimates of both the contact and no contact population of people with diabetes and high-risk feet and assuming the risk of amputation was the same, than the number of expected amputations in the no contact group should have been 55, however the observed number was 77, 22 more than expected ($p = 0.0001$).

Conclusions: Patients with no contact with a MDT-HRFS represented the majority of admissions for DFIs to a tertiary referral hospital. This group on population estimates appears to be at high risk of amputation of the lower extremity and therefore early referral of this high-risk group might lower this risk.

Background

Foot infections are one of the most common causes of hospitalisation in people with diabetes [1, 2] with up to 85 % of cases proceeding to a diabetes related lower extremity amputation [3]. Most frequently DFIs are preceded by ulceration, where a break in the protective barrier of the skin leaves a portal of entry for invading pathogenic organisms. The deficit in the immune-mediated response in people with diabetes may increase the risk and severity of foot infections but the exact underlying process responsible for this deficit, remains poorly characterized [4]. Early recognition and appropriate

management of diabetes related foot pathology preceding DFI's therefore is essential.

Primary care practitioners while providing the majority of medical care for people with diabetes, also play an important role in routine screening, identifying the risk of diabetes related foot pathology and referral needs [5]. High risk foot stratification includes two or more risk factors (peripheral neuropathy, peripheral vascular disease, deformity) and/or a history of ulceration, and/or amputation [6]. Clinical guidelines recommend primary referral of people with a high risk foot to a MDT-HRFS with specialist care from medical, surgical, nursing, podiatry and allied health professionals [5, 7, 8].

Emergency referral to a MDT-HRFS within 24 h is recommended when there is a new ulcer, swelling or foot discolouration [8]. Grading severe infection on the Infectious Disease Society of America (ISDA) guidelines,

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Chiropractors Look Forward to Foot Care Review

Published by Norm Tollinsky on December 15, 2015 in the Northern Ontario Medical Journal

Chiropractors Tina and Patrick Rainville hope pending changes to the model of foot care in Ontario will result in a better appreciation of their expertise by doctors and patients.

Archaic designation will more than likely be abandoned in favour of podiatry

Chiropractors Tina and Patrick Rainville, a husband and wife team practicing in Timmins, are hoping that a Health Profession Regulatory Advisory Council (HPRAC) review of foot care in Ontario will give them and 600 other chiropractors in the province some respect.

Chiropractic, an archaic designation that no one else in the world uses and few people are familiar with, will more than likely be abandoned. Chiropractors in Ontario will be known as podiatrists. The Rainvilles hope that with a better understanding of who they are and what they do, more doctors will refer to them and more patients in need of foot care will seek their services.

The origin of the chiropractic designation in Ontario dates back to 1981 when the province sought to resolve a shortage of foot care specialists. Aside from some U.S. trained podiatrists, foot care was provided by family doctors, dermatologists and orthopedic surgeons. At the time, there was no training of foot care professionals in the province.

The British model of chiropractic was chosen rather than the U.S. model, a chiropractic program at the Michener Institute for Applied Health Sciences was launched and the College of Chiropractors of Ontario was established.

But fast-forward 34 years and a lot of Ontarians still don't know what a chiropractor is, complain the Rainvilles.

The Rainvilles hope that with a better understanding of who they are and what they do, more doctors will refer to them and more patients in need of foot care will seek their services.

In every other province, foot care specialists are called podiatrists. Even the British have relegated the chiropractic designation to the dust bin of history, they noted.

Then there's the issue of whether chiropractors or podiatrists can be called doctors.

Podiatrists in the U.S. are allowed to call themselves doctors. So are podiatrists in Saskatchewan. However, in the U.S., the training is more extensive, and includes a surgical residency qualifying



podiatrists there to do bone surgery.

In Ontario, "chiropractors are not considered doctors," said Patrick. "We can't use that title, but when you get down to the gist of it, we are foot doctors."

"Chiropractors and podiatrists have the highest level of foot health training of any of the regulated professions. We're trained to provide the most comprehensive care. We treat diabetic foot wounds, we do foot screening and surgery, prescribe medications and fit patients with off-loading devices, orthotics and walking braces."

The current review is unlikely to allow the Rainvilles to call themselves doctors, but the switch from chiropractic to podiatry will help more patients get the specialized care they need.

Currently, most of their patients are self-referred. "They aren't coming to us from family doctors. It's all word of mouth," said Patrick.

If someone in Timmins has a foot problem and tries to find a

Continued next page

podiatrist in the Yellow Pages, they're going to come up blank and assume they have to go to Toronto for treatment, he complained.

Some will go to their family physician. Others will put off seeing anyone until their problem is so severe that they end up in the Emergency Department.

Training

"Family doctors typically don't enjoy dealing with warts, ingrown toenails, and diabetic wounds," said Tina. "Our profession is the most expertly trained in treating and surgically repairing ingrown toenails, but we'll often see patients who have gone through a lot of uncomfortable and painful treatments that didn't result in resolution because they sought treatment in the ER. It doesn't mean they're doing anything wrong. It's just not their area of expertise and they probably don't want to see (these patients) anyway. Finally, they land on our doorstep and say, 'If I had only known,' and I say, 'If you had to have a tooth pulled, you'd probably go to the dentist, not to Emerg.'"

If more patients turned to chiropodists and podiatrists, the wait time to see family doctors would be reduced, Emergency Departments would be less crowded and there would be fewer amputations resulting from untreated diabetic foot complications, say the Rainvilles.

Doctors recommending orthotics for their patients should also be aware that chiropodists are the only regulated health care professionals with the provision of orthotics within their scope of practice.

Currently, there's nothing to stop anyone from selling orthotics. Chiropractors, physiotherapists, pedorthists and even some foot care nurses sell them, despite the fact that it's chiropodists who

The Rainvilles also call attention to a recent incident of insurance fraud involving an orthotics business in Toronto that conspired with Toronto Transit Commission employees to bill the transit operator's employee benefits plan for up to \$4 million worth of bogus claims.

have expertise in the biomechanics of the lower extremities, and writing proper prescriptions for orthotics.

"Chiropractors don't have that expertise," said Tina. "Just like I don't adjust people's backs. It all comes down to what's in the best interest of the patient. When someone requires orthotics, you want the most accurate and precise prescription to resolve the patient's foot condition. You want the most expertly trained provider.

"Also, when treating foot conditions, orthotics is only one modality. If someone has foot pain and the only treatment is a

prescription for orthotics and nothing else, then there's less of a chance that the condition is going to resolve. When they see a chiropodist or podiatrist, we also offer therapeutic treatments. We have laser therapy. We can prescribe medications. We can do cortisone injections."

Insurance fraud

The Rainvilles also call attention to a recent incident of insurance fraud involving an orthotics business in Toronto that conspired with Toronto Transit Commission employees to bill the transit operator's

"We fly people up from Toronto to help us out because we need another chiropodist and can't get anybody because the program only graduates 25 people a year."

employee benefits plan for up to \$4 million worth of bogus claims. The business created fake invoices for orthotics, knee braces and socks, then split the cash with the employees.

Insurance companies generally require a prescription from a doctor or chiropodist, but don't always insist that the actual provider of the orthotics is qualified.

"Some patients will go to their family doctor and ask for a prescription for orthotics...but it's not a detailed prescription...and the patient goes to Joe down the road who is not trained," said Tina. "This is how doctors can get unknowingly involved in fraud."

Patrick, who is from Timmins, met Tina while both were enrolled in the chiropody program at the Michener Institute for Applied Health Sciences in Toronto. They began practicing in Timmins in 1997 and are the only chiropodists, or podiatrists, in the city.

Despite the lack of understanding about chiropody, there is no shortage of clients.

"We fly people up from Toronto to help us out because we need another chiropodist and can't get anybody because the program only graduates 25 people a year."

The Health Professions Regulatory Advisory Council submitted its report on the regulation of chiropody and podiatry and the model of foot care in Ontario to the Ministry of Health and Long-Term Care on August 31, 2015. The Ministry is now reviewing its recommendations and is expected to move forward with changes in the near future.

The Ministry is now reviewing its recommendations and is expected to move forward with changes in the near future.

Walk this way for wound treatment and prevention education and resources

The Canadian Association of Wound Care (CAWC) is a non-profit organization bringing together health-care practitioners, educators, researchers, industry leaders and policy makers with the goal of improving wound treatment and prevention.

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Michener Chiropody at the Rama First Nation Health Fair

By Vanessa Brunato and Alexandra Elliott, Third Year Chiropody Students

As chiropody students, we are often asked the question, “What made you decide you want to work with feet?” We all seem to have a standard, go-to response to this question. Some outline the fact that chiropodists are primary health care practitioners who operate their own practices and work independently. Others note that the profession can be incredibly rewarding. Some discuss the day-to-day variety of working as a chiropodist.

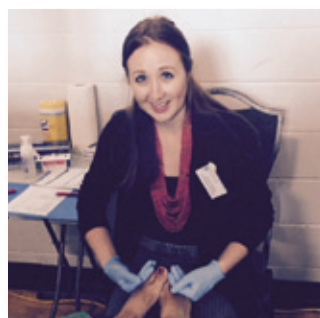


Whatever the answer we give, the bottom line is this: feet are pretty important. Aside from their obvious function facilitating mobility, feet have other important roles in health. Sometimes, a small symptom or change in the foot can signify the presence of a much larger problem with the body, such as a systemic condition. In the field of chiropody, we are given the opportunity to work with many different subsets of the population, and to be a first-line practitioner in different communities with many varying needs.

One such community is Chippewas of Rama First Nation. Located 90 minutes east of Toronto, this community has a population of approximately 1,500 and sits on the eastern shore of Lake Couchiching. Chippewas of Rama First Nation are self-described as a progressive First Nation community and are committed to improving the vitality of their community through a variety of initiatives, including health promotion, enhancing health care facilities within Rama First Nation and improving accessibility to community services.

To support this initiative, Rama First Nation held a community health fair on Thursday, September 24, and The Michener Institute Chiropody department decided to take part by providing free foot assessments to the public with registered chiropodist Ed Moley.

Our attendance at the Rama First Nation's health fair was informative and eye-opening. We had the opportunity to meet the community elder, a respected member of Rama First Nation, whose role is to mentor and uphold aboriginal culture and beliefs. We also learned how to approach health care within this unique subset of the Canadian population. For instance, diabetes is a disease that affects many aboriginal peoples and sometimes discussing this condition with First Nations groups can lead to feelings of mistrust and stress. Like all other populations, it is important when providing education to know the audience and find ways to make the topic both interactive and non-threatening.



The Southern Ontario Aboriginal Diabetes Initiative (SOADI) has developed a method to accomplish this through the creation of an educational series of pamphlets that link the varying areas of diabetes management to different animals. Foot care and diabetes within the Aboriginal community is represented by the rabbit. The rabbit provides comfort and tries to eliminate negative feelings, nervousness and fear. By approaching conversation in this manner, the health care practitioner is able to promote foot health and try to encourage a safe environment where members of the community will not be afraid to seek professional help when needed and have their feet examined.

Our experience at the Rama First Nations Health Fair taught us an invaluable lesson: successful health care delivery can only be accomplished through effective communication and, sometimes, the traditional form of health care communication is simply insufficient. Future chiropodists and other health care practitioners who aspire to work with First Nations communities are encouraged to work with organizations such as SOADI in order to develop an approach to health care delivery. By changing our approach to communication we might be able to improve voluntary attendance of at-risk community members which will help to advance the overall health care landscape in Canada.

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Highlights of the 2015 CFPM Annual Conference

On Nov. 6 & 7, 2015, the CFPM Annual Conference took place at the Westin Hotel in Ottawa, ON. Delegates were treated to phenomenal lectures and workshops that included Scott Wearing from Australia and Alan Borthwick from the UK. Delegates, exhibitors and speakers were entertained by Adam Grove and his unique form of comedy and Quiz Show. Congratulations to the winners of the CFPM Exhibitor Awards, LEO Labs, SIMS Medical and Medical Mart. Be sure to attend next year's CFPM Annual Conference, Nov. 11 & 12, 2016 in Mississauga, ON.



Quiz Show contestants: Tina Rainville, Peter Greaves with Host, Adam Grove



Big money winners: Linda Kim and Sarah Higgins



Quiz Show contestants: Rick Werkman and Randy Moore



Winners of the Dr. Brian Brodie Award for Research: Megan DeSimone, Alexandra Elliott and Anabela Lopes



Speaker: Scott Wearing



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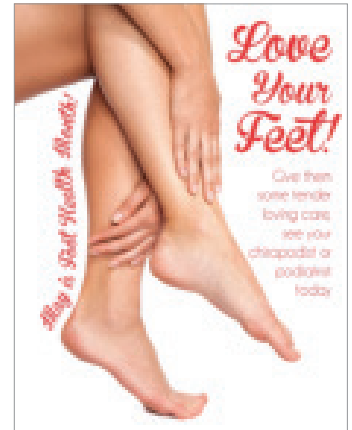
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predicted hospitalisation and amputation rates 89 and 70 % respectively [6]. High-risk foot services have demonstrated reductions in hospital admissions [9], amputations [10–16] and length of stay (LOS) [9, 12, 13, 16–18] for patients known to the service. However, despite clinical success rates and guidelines, many people with diabetes do not receive routine screening for diabetes related foot pathology to enable appropriate early referrals [5].

While the main focus within the literature surrounds MDT-HRFS and the reduction of DRLEA rates, there has been no comparison of hospital admissions for DFIs between people with contact and no contact to a MDT-HRFS. The primary aim of this study was to determine if patients with no contact to a MDT-HRFS were associated with increased numbers of hospital admission for diabetes foot infection. Secondary aims were to report on clinical outcomes in patients hospitalised for DFI, with a focus on any surgical procedures required, LOS, infection classification and cost.

Methods

A retrospective study was conducted at a major tertiary referral hospital in metropolitan Sydney from 1st January 2012 to 1st January 2013. Ethical approval was obtained from South Western Sydney Local Health District Research and Ethics Committee. Patient information including age, gender, medical history, clinical, laboratory, operative report data and hospital metrics were collected. Patients were eligible if they had either type 1 or type 2 diabetes with a primary admission for DFI. Patients were identified using the ICD-10 coding system.

District-linked electronic medical records and paper medical charts were cross-referenced and used to identify patients with 'contact' and 'no contact' to the MDT-HRFS. Patients with contact were defined as any registered patient attending an outpatient appointment with the MDT-HRFS in the preceding 12 months prior to admission. A MDT-HRFS was defined according to Agency for Clinical Innovation, Endocrine Network standards for high-risk foot services in New South Wales, Australia. There are four MDT-HRFS in the administrative district, each located in a public hospital outpatient area.

People with diabetes and peripheral neuropathy constitute a group at high risk for lower limb amputation as a consequence of ulceration and infection. While neuropathy has been identified as an etiology in the majority of DFI foot ulcerations [2, 19], peripheral vascular disease is present in over half [2] of those requiring hospitalisation and is a predictor of poor healing [2]. The size of this group in our Health District is not known, but estimates can be generated. The population of the Health District is 820,000. Approximately 8 % will have diabetes [19], and of these about 60–70 % will have peripheral neuropathy and or peripheral arterial disease. The severity of

the neuropathy and or peripheral arterial disease is likely to be normally distributed, and 20 % could be categorized as being in the high risk group [20]. This gives a target population at high risk of diabetic foot disease of approximately 8500 people. There are approximately 2500 'known' patients on the patient register of the High Risk Foot Clinic at our hospital location. 'Unknown' patients to the High Risk Foot Clinic with high risk foot pathology are estimated to be around 6000, derived from subtracting the 'known' patients from the target at risk population of 8500.

Outcomes of interest were: any foot surgery or vascular procedure associated with the index admission, the length of hospital stay, severity of infection (using current Infectious Disease Society of America guidelines for diabetes foot infection [2], inflammatory markers, culture results, and estimated hospital costs. Past medical history including comorbid variables in addition to clinical and laboratory data were confirmed using current diagnostic guidelines and obtained from both electronic medical records and paper charts. In particular, PAD was confirmed via documented clinical assessment and or in combination with available vascular studies. Diabetes peripheral neuropathy were confirmed through available clinical indicators including a modified neuropathic disability score >6 [21] absent 10 g monofilament in >3 places on the foot [22] and or available diagnostic electrophysiological studies.

Identified patients for the study were split into two cohorts, contact and no contact to a MDT-HRFS.

Costs for each inpatient separation were calculated utilizing AR-DRG (Independent Hospital Pricing Authority). All values are represented in AUS \$. For each patient, the admission, discharge date, principal diagnosis, principal procedure and co-morbidities were extracted and cross checked between electronic records and paper charts.

The cost of each individual patient episode of admission was calculated. Multiple procedures during a single admission were not calculated, and the cost was attributed to the highest surgical procedure cost. Thus if a patient required revascularization and amputation, the cost for amputation would be calculated as it is the higher costing procedure. The cost of multiple admissions within the 12-month period was also calculated for individual patients.

Statistical analysis

Statistical analysis was undertaken using IBM Statistical Packages for the Social Sciences (SPSS) Version 21.0 for Windows (SPSS Inc, Chicago, IL, USA). Unpaired t tests and chi square with risk ratio were employed in testing differences between cohorts. Mann-Whitney *U* test was used for nonparametric data. A histogram for hospital metric data was performed to look for outliers and normality. For

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Now Life Makes Sense A UK Podiatrist in Saskatchewan

By Georgie Evans

Towards the end of my one year fixed contract with the National Health Service in Oxford, England, I began looking at my options: I could renew my contract; find a job elsewhere in England; or look for a job in Canada. The plan had always been to emigrate to Canada, so I addressed that first. Whilst browsing job sites, I came across an advertisement for a job in a place I had never heard of in a province I had barely come across. I applied for the job and was invited to an interview. So I sat in my living room in my rented house in Oxfordshire and Skyped with my potential employer at 10pm on a Tuesday night.

I received a job offer with a work permit application package about one week later and after some consideration I decided to take a leap of faith and move to Swift Current, Saskatchewan. Over the next few months my fiancé and I put our wedding plans on hold and began completing the paperwork and attending the appointments required for us to obtain a work permit on entry into Canada. The permit would be valid for two years from date of issue.

The date of departure came quickly and we were soon standing in Calgary, Alberta with valid work permits in our passports. We stayed a few days in Calgary before flying onwards to Regina in Saskatchewan where we met my new boss.

I have now been here for nearly 18 months, which has gone very quickly. The biggest difference between podiatry in England and podiatry in Canada is the scope. Here I can use my full range of skills – seeing anything from basic footcare to nail surgery to musculoskeletal complaints to wart treatments. In addition to the clinic in the city of Swift Current, there are three satellite clinics for patients who are unable to drive the hour or more into the city. It adds to the variety of the job to be able to visit one of three different clinics each week and work in a different environment, in addition to being able to bring podiatry treatment to patients who aren't able to travel.

I have brought a lot of what I liked about podiatry in the UK to the practice here in Canada, perhaps most importantly the development of a role for a podiatry technician who provides basic footcare in a support role, allowing for a reduction in wait times and opening up appointment times for more complicated cases.



In addition to the clinic work, I also attended the CFPM conference in Ottawa – a city I had not been to – where I met new people, caught up with old faces and accessed up-to-date information on the latest developments in the field. I am also a member of the board of the CFPM, which provides a great opportunity to represent podiatry in Saskatchewan.

The tagline for Swift Current is “Where Life Makes Sense” and now we have been here a while, my fiancé and I have bought a house; brought my pet dog Tilly over from the UK; rescued another dog and some cats; bought a car; gone snowboarding, skating, wakeboarding, camping and joined various groups in town along with making friends with the locals. I think you could say we have settled in! We are now able to plan our wedding, which requires some jumping through hoops with regards to the paperwork – we have to be in the UK for 9 days before applying for our marriage license, and 28 days before the wedding date – but we have managed it and our temporarily paused plans are now back in motion. Perhaps most importantly we plan to stay here – our permanent residency application is churning along. Many people have told us that Swift Current is a lovely place to bring up a family and we are looking to the future where the plan is to take over the practice now that the previous podiatrist has retired.

When I was at University, my plan was to move to Canada. Having never heard of Swift Current, Saskatchewan, taking this particular job was somewhat of a gamble, but it has paid off in a big way. Saskatchewan is beautiful, Swift Current is friendly and welcoming, and every morning I wake up for work excited for what the day will bring.



all comparisons and modelling, the level of significance was set at $p < 0.05$.

Results

A total of 196 hospital admissions (156 patients) were identified from the ICD-10 search over the 12 month study period. Of the 156 patients, the majority had no contact with a MDT-HRFS (no contact = 116, 74.7 % vs. contact = 40 patients, 25.6 %, $p = 0.0001$). Patient characteristics including age, gender, medical history, clinical, laboratory and surgical procedures are identified in Table 1.

Surgery

A large number of patients admitted for DFI required a surgical procedure ($n = 126$ out of 156, 81 %) and the majority of these were undertaken in patients with no contact ($n = 94$ out of 126, 74.7 %). Amputation was the most common surgical intervention ($n = 100$ out of 126, 72 %) with lower extremity amputation being undertaken more frequently in patients with no contact (no contact = 77, 82 % vs. contact = 23, 72 %, $p = 0.23$). Population estimates for our groups suggested that admission and amputation in the no contact group were over represented, the expected number of amputations should have been 55, however the observed number was 77, 22 more than expected ($p = 0.0001$).

Revascularisations utilising percutaneous transluminal angioplasty (PTA) were performed in 34 (36 %) of no contact patients and 6 contact (19 %) patients with a trend towards significance ($p = 0.054$). Regardless of contact status, digital amputations were the most commonly performed amputation ($n = 67$, 43 %).

Length of stay

On average, the median LOS in the no contact group was 3 days longer than those with contact (contact = 8 days, IQR 7 to 12 vs. no contact = 11 days, IQR 6 to 24, $p = 0.063$). LOS was influenced by the requirement to undergo a surgical procedure. Regardless of contact status, the LOS for admissions not requiring surgery was 7 days (IQR 5 to 10 days) while LOS increased to 11 days in those patients undergoing a surgical procedure (IQR 8 to 21 days, $p = 0.008$).

Infection severity and classification

IDSA moderate infection was the most common presentation regardless of contact status ($n = 105$ of 156, 67 %). IDSA severe infection presentations occurred in 34 % ($n = 39$ of 116) of the no contact group and 30 % of the contact group ($n = 12$ of 40, $p = 0.67$), however no contact patients presenting with IDSA severe infection required greater numbers of lower extremity amputation with odds of 4.9 times higher than those with contact to a

MDT-HRFS (no contact with severe infection and amputation = 34, 82.9 % vs. contact with severe infection and amputation = 7, 17.1 %, OR 4.9, 95 % CI 1.1 to 21.4, $p = 0.037$).

Laboratory data

Inflammatory markers were similar between groups, with no significant difference; white cell count (no contact = $12.1 \times 10^9/L$, IQR 10 to 15 vs. contact = $10.7 \times 10^9/L$, IQR 8 to 15, $p = 0.241$, 95%CI-0.87 to 3.45), erythrocyte sedimentation rate (no contact = 57 mm/min, IQR 26 to 77 vs. contact = 57 mm/min, IQR 34 to 86, $p = 0.69$), C-reactive protein (no contact = 76 mg/L, IQR 32 to 172 vs. contact = 70 mg/L, IQR 23 to 155, $p = 0.99$).

Culture results

Two hundred fifteen pathogens of suspected infection were isolated from soft tissue and bone cultures in 129 patients. Polymicrobial infections were more common than monomicrobial infections (monomicrobial = 44 patients, 28.2 % versus polymicrobial = 85 patients, 54.5 %). Culture results were unavailable for 27 patients (17.3 %) who all received empiric antimicrobial therapy.

Gram-positive cocci were the predominating pathogens with the combination of *Methicillin-sensitive Staphylococcus aureus* (MSSA) and *Methicillin-resistant Staphylococcus aureus* (MRSA) accounting for half of all gram-positive cultures (MSSA = 37 of 118, 31 % and MRSA = 31 of 118, 26 %). Gram-negative bacteria represented 47 % of cultures with gram-negative rods predominating as probable colonisers (71 %, 69 of 97).

Cost analysis

The estimated total cost of foot infection in this cohort was \$4,264,214. The total cost was significantly higher in the no contact \$ 3,169,083 primarily due to the higher rate of patient presentation and surgical intervention. In comparison, the contact group costs amounted to 97 % less in total costs, (\$1,095,131) however, the average cost per patient separation was similar between groups (no contact = \$ 22,475 vs. contact = \$21,473, $p = 0.763$).

Discussion

While evidence exists for reduction of diabetes related lower extremity amputation through the use of multidisciplinary high risk foot care services [10, 23, 24] the link between reduction in infections and the use of multidisciplinary foot services is less clear. This retrospective study suggests access to the MDT-HRFS within the hospital at the time of admission for DFI provides similar clinical outcomes regardless of contact status prior to admission. However, in this study patients with DFI who had no previous contact with a MDT-HRFS constituted

Continued next page

**Table 1** Patient characteristics for contact or no contact with a MDT-HRFS

	Contact (n = 40)	No Contact (n = 116)	Total (n = 156)	p-value
Demographics				
Mean Age (\pm SD)	63.4 (\pm 11.8)	65.5 (\pm 14.1)	65 (\pm 13.5)	0.40
Male, n (%)	27 (67.5)	78 (67.2)	105 (67.3)	
Female, n (%)	13 (32.5)	38 (32.8)	51 (32.7)	0.98
Medical history				
Diabetes Type 1, n (%)	4 (10.0)	8 (6.9)	12 (7.7)	
Diabetes Type 2, n (%)	36 (90.0)	108 (93.1)	144 (92.3)	0.54
Duration of Diabetes (\pm SD)	15.5 (\pm 5.7)	15.8 (\pm 8.5)	15.7 (\pm 7.8)	0.86
HbA1C (mmol/mol)/IFCC	8.4 (\pm 2.2)/68	8.7 (\pm 2.6)/72	8.6 (\pm 2.5)/70.5	0.44
Peripheral Neuropathy, n (%)	35 (87.5)	97 (83.6)	132 (84.6)	0.56
Peripheral Arterial Disease, n (%)	33 (82.5)	95 (81.9)	128 (82.1)	0.93
Ischemic Heart Disease, n (%)	20 (50)	58 (50)	78 (50)	1.00
Hypertension, n (%)	36 (90)	98 (84.5)	134 (85.9)	0.39
CKD stage 5, n (%)	9 (22.5)	19 (16.4)	28 (17.9)	0.21
eGFR (\pm SD)	41.3 (\pm 26.5)	47.8 (\pm 28.7)	46.2 (\pm 28.2)	0.001*
Length of Stay, n (IQR)	8 (7–12)	11 (6–24)	10 (10–19.5)	0.63
LAB				
White Cell Count, n (IQR)	10.75 (8–15)	12.1 (10–15)	11.8 (9–15)	0.24
Presenting ESR (mmol/L), n (IQR)	57 (34–86)	57 (26–77)	57 (27–77)	0.69
Presenting CRP (mg/l), n (IQR)	76.35 (23–155)	69.75 (32–172)	73.7 (29–166)	0.99
Infection severity				
IDSA grade Moderate, n (%)	28 (70 %)	77 (66.4 %)	105 (67.3 %)	0.68
IDSA grade Severe, n (%)	12 (30 %)	39 (33.6 %)	51 (32.7 %)	0.68
Texas classification				
1B, n (%)	1 (2.5)	6 (5.2)	7 (4.5)	0.48
1D, n (%)	6 (15)	21 (18.1)	27 (17.3)	0.66
2B, n (%)	3 (7.5)	11 (9.5)	14 (9)	0.71
2D, n (%)	12 (30)	52 (44.8)	64 (41)	0.10
3B, n (%)	3 (7.5)	5 (4.3)	8 (5.1)	0.43
3D, n (%)	15 (37.5)	21 (18.1)	36 (23.1)	0.01*
Surgery type				
Surgical debridement, n (%)	7 (17.5)	28 (24.1)	35 (22.4)	0.39
PTA, n (%)	6 (15)	34 (29.3)	40 (25.6)	0.08*
Bypass, n (%)	0 (0)	3 (2.6)	3 (1.9)	0.31
Amputation, n (%)	23 (57.5)	77 (66.4)	100 (64.1)	0.32
Forefoot/digital, n (%)	16 (40)	51 (44)	67 (42.9)	0.66
TMA, n (%)	0 (0)	0 (0)	0 (0)	
BKA, n (%)	8 (20)	18 (15.5)	26 (16.7)	0.51
AKA, n (%)	0 (0)	8 (6.9)	8 (5.1)	0.09*

ESR erythrocyte sedimentation rate, CRP c-reactive protein, CKD chronic kidney disease, eGFR estimated glomerular filtration rate, PTA percutaneous transluminal angioplasty

*p-value <0.05



around three times the number of hospital admissions for lower extremity amputation compared to those with prior contact. Whilst this rate of lower extremity amputation was not significantly different between the two groups, population estimates suggest that the number of expected amputations in the no contact group should have been 55, however the observed number was 77, 22 more than expected.

The large numbers of patients with no contact to MDT-HRFS within a large district in Sydney, Australia is of concern, particularly with four services in our District, with a no-wait policy for urgent referrals. Population estimates suggest this group are over represented in relation to admission and amputation rates. Screening is the key to identify people with diabetes who are at risk of ulceration and complication [25]. This has been emphasised in many health policy documents [7, 8]. A large component of this work is often undertaken within the primary care setting. Whilst the baseline characteristics of the contact and no contact group were similar, it is surprising given the long standing duration of diabetes and co-morbidities that referral to a MDT-HRFS did not routinely occur.

Our results are consistent with the contention that MDT-HRFS reduce the risk of amputation particularly in association with severe infection. Severe DFI was associated with a five-fold increase in the odds of requiring a lower extremity amputation. Using the same criteria for grading severity of infection as in this study, Wukich and colleagues evaluated the outcomes of patients with moderate and severe DFI. Their retrospective study of 119 patients reported a similar seven-fold increase in the risk of patients undergoing amputation if they presented with severe DFI (7.12 RR 95 % CI 1.83-41.05) [26].

The median LOS in patients with no contact was three days longer than those with contact. While this was not significant between the groups the additional hospital days are associated with an increased burden on the healthcare system and this number is higher than national averages for admission with cellulitis without complications [27]. The most likely explanation for this finding is the higher number of surgical procedures undertaken during admission in this study population.

This study has limitations that should be noted. The retrospective design relies heavily on both the ability of the treating team and the clinical coding team to accurately capture all relevant patient data and assign a correct primary diagnosis [26]. Errors may also occur in the ICD-10 conversion to the correct DRG [28]. A prospective study would allow greater accuracy in coding and classification.

The AR-DRG clinical coding which is used to estimate healthcare costs can be influenced by under and over-coding and by coding errors. In this study, these problems were avoided by allocating AR-DRG codes for each

submission after manually cross-referencing all of the data between the ICD-10 search, eMR and patient paper charts, rather than relying solely on the patient paper charts.

Conclusion

This single-centre study indicates that patients with no contact with a multi-disciplinary high risk foot service account for around 75 % of hospital admissions and amputations for DFI. Given the evidence about the effectiveness of MDT-HRFS and the need for early identification and prevention the over representation of the no contact group is of concern. Appropriate referral and early access to these specialist clinics is needed. Primary health carers and general practitioners should be aware of patients that should be referred to MDT-HRFS. Future studies should be prospective and a multi-site study would provide a national perspective. Studies should also explore the potential barriers to early referral for those at risk of admission for complications of diabetes foot disease.

Competing interests

No relevant disclosures.

Authors' contributions

DP collected data, designed data collection forms and undertook a literature review for the introduction. MM and SP undertook statistical analysis and provided input into the first draft of the article. HGD, MM and SP were responsible for the final draft paper. All authors read and approved the final manuscript.

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Classified Ads



Practice for Sale – Bracebridge, ON

- Established Muskoka Practice for sale.
- Owner retiring.
- Large office in purpose built building.
- Lease renewable.
- Free patient parking.
- Wheelchair accessible.
- Only practice in Bracebridge: serving a wide area.
- Huge potential for growth.
- Negotiable terms.
- 2 treatment rooms, casting room and office room.
- Room for expansion.
- Fully furnished waiting room.
- All equipment and inventory included.

For more information please contact:
muskokafootclinic@bellnet.ca
or Margaret Carey @ 705-645-4613.

Podiatry/Chiropody Position Available – Markham, ON

Podiatrist/ Chiropodist/ Partner – Flexible
schedule & Hours

Location: BioPed Lower Limb Clinic at 4981
Highway 7 East Markham, Ontario (North
Toronto)

Become a partner in the largest franchise
provider of lower limb care in Canada. Our
Markham clinic has been established for
over 15 years; we are highly respected for
ethical and comprehensive patient care and
an existing customer base. We are seeking a
patient-focused Chiropodist/ Podiatrist in good
standing with the COCOO/license to practice in
Ontario. With support from our award winning
head office, 2 current owners and an office
manager, we have you set up for convenience
and success! Compensation package is
competitive, and a work to own or buy-in option
is available if we are the right fit.

We are looking for someone who will....

- Demonstrate competence in Chiropody skills,
- Be personable and possess excellent
communication and team work skills
- Be self-motivated and committed to
excellence in patient care
- Be registered in good standing with COCOO
and carry Professional Liability Insurance

Responsibilities include...

- a. Diagnose diseases, deformities and injuries
of the human foot and treat patients using
braces, casts, shields, compression, OTC
products, orthotic devices, physical therapy
and subcutaneous soft-tissue foot surgery.

- b. Offer treatment for the relief of painful
symptoms of dermatological and other foot-
related problems, including hard skin, corns
and calluses, verrucae (warts), in-growing
nails, fungal infections
and bunions.
- c. Maintain a level of care that meets cultural,
holistic, ethical standards based on the
licensing body.
- d. Provide vascular and neurological
assessment in the long-term management
of chronic disorders and specialist high
risk patient groups such as the elderly and
those suffering from conditions where the
possibility of amputation must be minimized.
- e. Develop and implement charting tools. Keep
record of appropriate statistics.
- f. Work with members of the clinic to plan and
evaluate on-going products and services.
- g. Develop or initiate health teachings,
screening programs or workshops. Identify
health needs of clients and various other
community groups.
- h. Referring physician visits and presentations.

Please contact: Ms. Kay Penn
T: 416-481-0530 E: kpenn@bioped.com
or Ms. Tania DeBenedetti
T: 289-260-3394
E: tdebenedetti@bioped.com

For Sale: Chiropody Clinic

Servicing Scarborough & Surrounding Area
Best location in Scarborough (Corner ground
floor office at Kennedy Subway)

- Turn key operation
- 20 year established chiropody clinic
- Very busy practice with great potential
for growth
- 2 exam rooms ,separate office and lab area
for orthotic adjustments
- 850 sq. ft. in established medical building
- Private washroom
- Free patient parking
- Wheelchair accessible
- Transferable lease
- Family Drs and Pharmacy on either
side of office
- Negotiable terms
- Well suited for active chiropodist(s)

Please contact Brian at
Brianpaulharper@gmail.com for more info.

Practice for Sale – Whitby, ON

Notice! Established Chiropody Private Practice
for Sale in Prime Location

A private practice in prime location is for sale
by the Chiropodist/Owner who is retiring from
the business.

Location: A high growth North Whitby area
within the Durham Region

What is Included? Everything!

- All active clients
- Fully furnished waiting room, and
office space
- Equipped treatment room with all equipment
and support
- Full clerical support provided in an
attractive lease
- Freedom to move practice to different
location if preferred

This is a long-standing, healthy and well-
respected practice with many active clients
and plenty of opportunity for further growth and
expansion. The practice has been operating
under a 4 day a week model (Monday-
Thursday).

Additional facts and attributes for this attractive practice include:

- Have been practicing in Durham Region for
29 years (13 years in private practice setting)
- Attractive lease that includes full time
CLERICAL support!
- Located in a state of the art facility
(Taunton Mills) with immediate plans for
further expansion
- Clinic adjacent to Health Centre that includes
Medical Services and GAIN clinic
- Fully furnished waiting room, office space,
treatment room, orthotic modification space
and gait analysis hallway.
- All equipment is provided and includes
supplies, instrumentation, and additional
storage space
- Motivated to sell. Willing to negotiate all
terms of sale and transfer

Consider this a great opportunity, avoiding the
difficulties and time required to start up a new
practice and build a client base.

Call today to explore this exciting and attractive
opportunity: Contact hartshorndean@gmail.com
for more info or call Dean Hartshorn at
905-665-0155.

Full Time Chiropody Position Available – Lindsay ON

Our Chiropody clinic has been established
for over 15 years; we are highly respected for
ethical and comprehensive patient care, we are
very busy and we continue to grow.

Continued page 28



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Classified Ads

The successful candidate will:

- Demonstrate competence in the FULL SCOPE of Chiropody skills,
- Be personable and possess excellent communication and team work skills
- Be self-motivated and committed to excellence in patient care
- Be registered in good standing with COCOO and carry Professional Liability Insurance

The clinic will:

- Provide exceptionally equipped professional surroundings (newly renovated office suite, dedicated assistant and reception, warm and welcoming staff and patients, etc).
- Provide competitive compensation

We are invested in providing the very best care for our patients. We have high expectations of ourselves and we will have high performance expectations of the successful candidate.

Please email resumes to info@astepaheadfootclinic.ca. Successful candidates will be contacted.

Chiropody Position Available – Whitby, ON

A busy multidisciplinary clinic would like to add a Chiropodist to our team in the Whitby area. The clinic is in a high foot traffic area and next to a walk in clinic with multiple Physicians, (8 General Physicians with 2-3 more being added in the future and 4 specialists) in the building creating a steady referral base. Terms to be discussed and are negotiable. New grads welcome to apply. Interested candidates please email wmauchdc@hotmail.com.

Chiropody Position Available – Toronto, ON

A well established multi-disciplinary clinic with multiple locations in the west end of the G.T.A offering Chiropractic, Physical & Massage Therapy, Laser & Traditional Acupuncture and complete foot care services.

Duties include: Complete foot care services & range of devices from gait analysis to wound care including bio-mechanical assessments, nail surgery, custom orthotics, orthopedic shoes, lymphedema garments custom bracing compression socks and shockwave therapy.

Enthusiastic, self-motivated licensed Chiropodist in good standing with great interpersonal, time management & computer skills whose a team player and works well with others in a multi-disciplinary environment.

Contact Name: PhysioCare & Rehab

Contact Email: physiocaremeadowvale@gmail.com

Salary: To be negotiated

Start Date: February 1, 2016

Hours: Full or Part time

Hours of Operation: M-F 10am – 7pm

Practice For Sale – Saskatoon, Sk

Well established, (over 30 years of practice) city centre Podiatry clinic across the street from City Hospital. Spacious well equipped clinic. Extensive referral sources from family physicians, specialists and many other health care professionals. Liaison with all of these groups is an integral part of the practice. A very lucrative business opportunity for the right Podiatrist

Genuinely interested practitioners please contact:

Hauck Podiatry Prof. Corp.

ATTENTION: Dr. Edward Hauck

203 – 514 Queen Street, Saskatoon, SK S7K 0M5

T: 306 653-4151 F: 306 653-4153

E: dr.e.hauck@shaw.ca

Continued next page

Classified Ads



Chiropody Practice For Sale – Sydney, Nova Scotia

Established 25+ years chiropody practice for sale in Sydney, Nova Scotia. This practice has an excellent referral base covering Cape Breton Island, Nova Scotia. Has great potential for growth. The practice offers a wide variety of services including general foot care/nail care, diabetic foot care, biomechanics/orthotics.

Inquiries can be made at
rmackwood@gmail.com.

Associate Position Available, Cornwall ON (New Grads Welcome)

We have a beautiful new facility and growing practice. The rapidly expanding demand for foot care requires us to find another Chiropodist for our clinic. The clinic has been servicing the area for more than 20 years. The clinic has state of the art equipment including a Surgical Suite, Cutera Laser, Shockwave Therapy, sport lasers, Anodyne laser, multiple combination therapy units and a Electro-surgical unit and much more. We are currently seeking a full time or part time Chiropodist. New graduates welcome. We are located in a border city only one hour from both Ottawa and Montreal along the 401 corridor. We have a great team of nurses and assistants that work exceptionally well as a group. We also have a full capacity on-site laboratory for the manufacture of orthotics and braces. Flexible hours and benefits. A partnership may be considered with the right candidate. Must be honest and highly motivated and willing to work as a team.

Please send resume to
footandankle@cogeco.net.

Full Time Position Available – Brandon, MB

We have a full time position that would be in our office in Brandon, Manitoba. It would suit a practitioner who is self motivated. There is opportunity for someone who is willing to do some travel. Need CPR and soft tissue surgery certified as well as a drivers license and licensure in Manitoba. We do much orthotics, electrosurgery and some wound care. Salary commensurate with experience.

Possible partnership option for right candidate. If interested, please contact drball@wcgwave.ca.

Part-time Chiropodist Position Available – Various locations

BioPed is Canada's largest group of Lower Limb Care Providers, servicing patients in Ontario, B.C. and Nova Scotia for over 30 years. BioPed is hiring a part-time Chiropodist at the following Ontario locations:

- Niagara *mileage will be provided to both Grimsby and St. Catharines locations
- Guelph
- Toronto (Etobicoke North)
- Hamilton (Stoney Creek)
- London & Chatham
- Brantford
- North Bay

This exciting opportunity provides the successful candidate with many perks including uniform, insurance coverage, medical and dental benefits*, conference stipends and a highly competitive salary. *dependent on hours worked

Duties include the assessment and treatment of foot conditions; including, but not limited to, diabetic foot care, nail care, biomechanical assessments, custom orthotic casting and dispensing, wound care, measuring for and dispensing compression stockings, procedures such as PNA/TNA/soft tissue lesion excisions, the provision of foot care products and footwear.

The Chiropodist is expected to work well in a team environment and must be willing to learn. We are happy to provide further education on compression, procedures or orthotic fabrication if desired.

Candidates must:

- Have valid registration and be in good standing with the College of Chiropodists of Ontario (COCOO) as well as possess BOTH prescription and injection privileges per the COCOCOO.
- Have regular access to a reliable vehicle, which they are insured for.
- Possess valid CPR.
- New/upcoming grads are welcome to apply today! Experience is an asset.

Please send your cover letter and resume to:
Andrea (Practice Leader) @
adicroce@bioped.com

Chiropody Position Available – Cornwall, ON

Enthusiastic Registered Chiropodist Burns Ortho-Medical – Cornwall, Ontario Burns Ortho-Medical is a well-established, busy, multidisciplinary Chiropody Clinic Serving Cornwall, Stormont, Dundas and Glengarry counties and surrounding area for over 15 years. Our rapidly growing clinic is looking for a full-time enthusiastic Chiropodist to join our team.

Qualified candidates must be:

- Registered in good standing with the College of Chiropodists of Ontario without any restrictions
- Carry Professional Liability Insurance

- Committed to excellence in patient care
- Positive and energetic
- A team player, with excellent communication skills
- Organized and highly professional
- New graduates are welcome to apply
- Fluently bilingual in both French and English would be an asset

Our clinic will offer you:

- Competitive compensation
- Health benefit package
- A health-care practitioner owned clinic with focus on quality service and patient care
- A professional, yet friendly work environment
- Administrative support staff

Qualified candidates are asked to please send their resume and cover letter to the attention of Christina by email to: burnsorthomedical@bellnet.ca or by fax to 613-930-6786.

Part Time Position Available – Oakville, ON

Position: Associate Chiropodist (Part Time)

Location: Oakville

Company: Orthopedics in Motion Inc.

Orthopedics in Motion Inc. is currently looking for an associate Chiropodist.

The Associate Chiropodist position is for 1-2 Days per week. The clinic is currently providing the full scope of Chiropody services including: Biomechanical Assessments and Gait Analysis, Prescribing/Dispensing Custom made Orthotics/Orthopedic footwear and General Foot Care.

The Clinic offers:

- Large, newly renovated treatment room (3D scanner available to use for foot scan)
- Administrative duties (billing and booking clients)
- Marketing/advertising
- Compensation is based on a percentage split

Responsibilities:

- Foot Care Services and Nail Surgery
- Custom Orthotics and Off the Shelf Orthopaedic Shoes

Qualifications:

- The candidate should be in good standing with the College of Chiropodist
- The candidate must carry Professional Liability Insurance

Interested Candidates please email
julid125@gmail.com.

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adjective; strongly or stoutly built.

INTUITIVE

adjective; readily learned or understood.

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verb; a belief that something is reliable, good, honest, effective.

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<http://www.acfap.org>

Apr. 14 – 17, 2016

Valley of the Sun Conference
Phoenix, AZ
www.podiatryinstitute.com

April 28 – 30, 2016

Australian Podiatry Conference
Sydney, Australia
www.podiatry.asn.au

Apr. 28 – May 1, 2016

Surgical Pearls by the Sea
Newport, RI
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May 13 – 14, 2016

AAPPM Spring Seminar
Chandler, AZ
www.aappm.org

May 19 – 22, 2016

Reconstructive Surgery
of the Foot and Ankle
Atlanta, GA
www.podiatryinstitute.com

June 10 – 11, 2016

CFPM Summer Seminar
Moncton, NB
www.podiatryinfocanada.ca

June 16 – 18, 2016

38th Annual Seattle Summer Seminar
Seattle, WA
www.internationalfootankle.org

June 23 – 26, 2016

Footprints in the Sand
Hilton Head, SC
www.podiatryinstitute.com

June 23 – 26, 2016

TPMA Annual Conference
Montgomery, TX
www.txpma.org

July 14 – 17, 2016

The National – APMA Conference
Philadelphia, PA
www.apma.org

July 22 – Aug. 3, 2016

Rhine River Cruise and Tour
Zurich to Amsterdam
www.internationalfootankle.org

Aug. 7 – 13, 2016

International Association
for Identification
Cincinnati, OH
www.theiai.org

Sept. 7 – 11, 2016

2016 Montana Meeting
Fort Smith, Montana
www.goldfarbfoundation.org

Sept. 9 – 11, 2016

Podiatry conference
Overland Park, KS
www.podiatryinstitute.com

Sept. 16 – 18, 2016

Podiatric Residency Education Summit
Chicago, IL
www.presentconferences.com

Sept. 22 – 25, 2016

Reconstructive Surgery
of the Foot & Ankle
San Diego, CA
www.podiatryinstitute.com

TPMA Southwest

Foot and Ankle Conference
Frisco, TX
www.txpma.org

Sept. 29 – Oct. 1, 2016

24th Annual Las Vegas Seminar
Las Vegas, NV
www.internationalfootankle.org

Oct. 7 – 9, 2016

Mid-Atlantic Conference
Falls Church, VA
www.podiatryinstitute.com

Oct. 14 – 16, 2016

Insights & Advancements
in Foot & Ankle Surgery
Philadelphia, PA
www.podiatryinstitute.com

Oct. 15 – 22, 2016

35th Annual Hawaii/Kauai Seminar
Kauai, Hawaii
www.internationalfootandankle.org

Oct. 19 – 21, 2016

Desert Foot Conference 2016
Phoenix, AZ
www.presentconferences.com

Oct. 20 – 23, 2016

"The Best Sports Medicine Meeting
in the Country"
Portland, Oregon
www.aapsm.org

Oct. 21 – 23, 2016

APMA Region One Conference
Boston, MA
www.podiatryinstitute.com

Oct. 26 – 29, 2016

CDA/CSEM Professional Conference
Ottawa, ON
www.diabetes.ca

Nov. 3 – 6, 2016

2016 Clinical Conference
King of Prussia, PA
www.goldfarbfoundation.org

Nov. 3 – 6, 2016

Annual CAWC Conference
Niagara Falls, ON
www.cawc.ca

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www.podiatryinstitute.com

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www.podiatryinfocanada.ca

Nov. 10 – 13, 2016

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www.aappm.org

Nov. 17 – 19, 2016

The College of Podiatry
Annual Conference
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www.scpod.org

Nov. 17 – 19, 2016

Superbones Superwounds West
Las Vegas, NV
www.superbonesuperwoundswest.com

Dec. 2 – 4, 2016

2016 Annapolis Meeting
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www.goldfarbfoundation.org

Dec. 2 – 4, 2016

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www.podiatryinstitute.com

2017

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Eastern Caribbean Cruise
www.internationalfootankle.org

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24th Annual Winter Conference
Park City, UT
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Feb. 26 – Mar. 2, 2017

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Las Vegas, NV
www.acfas.org

Feb. 27 – 30, 2017

Midwest Podiatry Conference
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July 27 – 30, 2017

The National – APMA Conference
Nashville, TN
www.apma.org

Aug. 6 – 12, 2017

International Association
for Identification
Atlanta, GE
www.theiai.org

2018

April 19 – 22, 2018

Midwest Podiatry Conference
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July 12 – 15, 2018

The National – APMA Conference
Washington, DC
www.apma.org

July 29 – Aug. 4, 2018

International Association
for Identification
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2019

Aug. 11 – 17, 2019

International Association
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www.theiai.org

2020

Aug. 9 – 15, 2020

International Association
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Orlando, FL
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2021

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